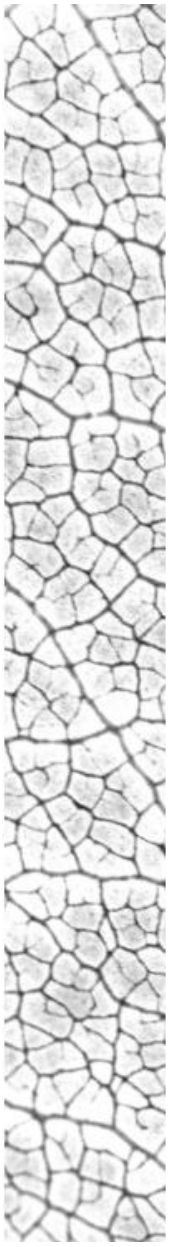

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Combating with ageism in care settings: A qualitative study

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Abstract

This study was conducted to collect and explore the experiences of hospital caregivers about strategies to deal with ageism in care settings. This qualitative research used conventional content analysis. Twelve nurses and physicians in Tehran hospitals were selected by purposeful sampling method and entered the study after data saturation. The study data were collected using in-depth and semi-structured interviews with open-ended questions. The interviews were recorded and then transcribed verbatim. The obtained data were analyzed with Hsieh and Shannon approach. After analyses of the interviews, 640 primary codes were extracted, which resulted in the emergence of two main categories of "caregiving is worthwhile" with four subcategories (Not considering caregiving a useless task, Not considering more valuable dead older people over alive ones, Not considering caregiving costly, Motivation for caregiving) and "caregiving is sensitive "with three subcategories (Being sensitive to the health of older people, Supervising and follow up, Education and culture-building). According to the study results, caregivers believed that the valuation of caregiving and being sensitive to caregiving were the most important strategies to deal with ageism in care settings. Therefore, health care decision-makers and authorities can reduce the likelihood of discrimination in the care provided to the elderlies by proper policy-making to promote caregivers' attitudes towards the worthwhileness and sensitiveness of caregiving.

Keywords: ageism, content analysis, ageing, valuing, sensitization

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INTRODUCTION

The number of older people has increased dramatically in recent years, and the World Health Organization (WHO) has projected that the global elderly population will reach two billion by 2050 (Saydshohadai et al. 2013). According to the 2017 census, the Census Center of Iran reported a population of 6.1 million over the age of 65 and over out of total 80 million (Statistical center of Iran 2018). Iran's population over 60 is expected to exceed 25 million by 2050 (World Health Organization Census 2012).

As the elderly population increases, the number of older people visiting hospitals also rises. Nevertheless, caregivers prefer to take care of young people, which lead to discrimination in care (Butler 2009, Officer et al. 2016). Discrimination in the provision of care is one of the most important clinical issues that should be properly addressed (Officer et al. 2018).

Misconceptions and negative attitudes towards the elderly are serious obstacles to the development of public health laws for the elderly. Negative attitudes towards older people, such as considering them as weak, sensitive, and dependent persons, are common all over the world (Officer et al. 2016). The older people are regarded as a barrier to economic growth and increasing care costs. These factors have reduced the respect for the elderly, increased restrictions on health policymaking, reduced resource allocation, and resulted in an improper prognosis for mortality among older people (Officer et al. 2016, Lioyd-Sherlock et al. 2016).

Ageism refers to having stereotypes, prejudices, and discrimination against a specific person or group of people based on their age (Butler 2009, 1969). Unlike other forms of discrimination like racism and sexism, ageism has remained mostly unknown (Cook 2011, Kingsley 2015). Discrimination based on gender, race,

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or age has many negative health consequences (Bussolo et al. 2015). Ageism reduces the sociability, health condition, and longevity of older people (Ayalon and Tesch-Römer 2018).

The fight against ageism has great potential for improving the physical and mental health of the elderly because these stereotypes and prejudices not only affect our behaviors, but the institutionalized discrimination in older people also would lead to a kind of self-ageism (Ayalon and Tesch-Römer 2018, Nelson 2004). Research has shown that people who have a positive attitude toward aging tend to live 7.5 years longer than people who have a negative attitude toward aging (Levy et al. 2002). Also, research indicates the discrimination against the elderly in public health and care (Levy et al. 2002, Ayalon and Tesch-Römer 2018) and that health care provider have a negative attitude toward the elderly more than other people in the community (Nash et al. 2014). These discriminations are mostly observed inadequate screening, preventive care, and poor treatment and health management (Dixon-Woods et al. 2006).

Therefore, changing attitudes and public opinion towards the elderly can preserve the large capacity of this group of human resources (Kingsley 2015). Although the elderly will eventually face numerous health problems, the high costs and dependency are not their most important problems (Cook 2011). For example, Japan is the only country that 30% of its population is over 60 years old. However, evidence shows the little impact of older people on economic growth (Bussolo et al. 2015). Considering the phenomenon of ageism and discrimination in caregiving and its negative consequences in older people's lives (Banister 2018), we need a serious understanding of older people and fighting against ageism (Sargent-Cox 2017). In 2016, WHO implemented the first global strategy and action plan for older people's health and called for a global confrontation with the phenomenon of ageism (Officer et al. 2016, Officer and de la Fuente-Nunez 2018).

Various studies have proposed different approaches, including intergenerational interaction education (del Carmen Requena et al. 2018), rights of older people (Larsson and Jonson 2018), and applying the older people's rights in national laws to fight against ageism (Georgantzi 2018). But it is challenging to confront ageism because of its hidden nature (Ayalon and Tesch-Römer 2018). On the other hand, the experience of opposing racism and sexism has shown that changing social norms is possible and can lead to more prosperous, balanced, and healthy communities (Officer and de la Fuente-Nunez 2018). Since caregivers deal with older people more than other people and possibly experience discrimination, they are the most qualified people to identify the problems and provide solutions for them.

In other words, being present in the field and examining the experiences of these people can help deal with this phenomenon. This qualitative study attempts to collect and explore the experiences of hospital caregivers and report their strategies to combat discrimination in providing hospital care to the elderly.

METHODS AND MATERIALS

This qualitative research was a conventional content analysis (Hsieh and Shannon 2005) conducted in 2018. The study population comprised caregivers working in Tehran hospitals. By caregivers, we refer to nurses and physicians. The participants were selected using a purposive sampling method with maximum diversity. The sampling was continued until data saturation.

The primary method of data collection was semi-structured interviews using open-ended questions. The interviews were conducted face-to-face in a relaxed setting chosen by the participants.

The interview first began with a few open questions: "What comes to your mind when taking care of an older person?" "What is your experience of discrimination in providing care to the elderly?" "What do you suggest to improve elderly care in hospitals?" Then, considering the answers and clarification and deepening of the conversation, the interview continued by other exploratory questions such as "explain more?" or "what do you mean?" The duration of the interviews ranged from 35 to 75 minutes. The interviews were conducted with 12 nurses and physicians until data saturation.

Hsieh and Shannon approach were used for data analysis (Hsieh and Shannon 2005). Based on this approach, the recorded interviews were initially transcribed verbatim, and the text was reviewed and re-read several times to understand the caregivers' experiences and to reach data saturation. In the second stage, the data texts were encoded. In the third stage, similar phrases and codes were merged into subcategories, and finally, the main classes were categorized into one overall structure considering semantic and conceptual similarities. In the fourth stage, the main classes and codes were evaluated several times for integration and review. Finally, with respect to the fight with discrimination in the provision of hospital care, two main categories based on the caregivers' experiences in the studied hospitals emerged.

Credibility, auditability, applicability, and conformability criteria were used to ensure data reliability (Sandelowski 1986). For the credibility of the research, we used open-ended questions so the participants could freely express their experiences about the subject under study while caregiving. The auditability of the information obtained in this study was confirmed by the quotations from caregivers at the end of their interviews. For applicability, the authors also consulted with caregivers who did not participate in the present

Table 1. Demographic characteristics of the participants

Number of participants	12 people
Sex	Male (7), Female (5)
The average age of the participants	38 y (24 to 52 y)
Educational field	Nurses:10 Emergency medicine specialist: 1 Anesthesiologist:1
The average work experience	12 y (3 to 21 y)

Table 2. Classification of the main categories and subcategories

Caregiving is worthwhile	1. Not considering caregiving a useless task
	2. Not considering more valuable dead older people over alive ones
	3. Not considering caregiving costly
	4. Motivation for caregiving
Caregiving is sensitive	1. Being sensitive to the health of older people
	2. Supervising and follow up
	3. Education and culture-building

study to review the mentioned ideas and express their agreement with the participants' experiences. To be ensured of the research conformability, we carefully recorded and registered the interviews, presented them to the experts, reviewed them by the supervisors, as well as using direct comments from the participants. Eventually, the final report was provided.

The present study is part of a Nursing PhD dissertation entitled "The Design and Validation of an Ageism Assessment Tool Among Hospital Caregivers" and has been approved by the Ethics Committee of the University of Social Welfare and Rehabilitation Sciences (Ethical code: IR.USWR.REC.2018.263). During the research process, from data collection to the end of analysis and reporting, such issues as informed consent, anonymity, the confidentiality of information, the right to withdraw at anytime, and the ethical obligations were observed. The study started by referring to hospitals and explaining the research procedure.

RESULTS

Twelve participants participated in the study until data saturation. **Table 1** presents their demographic characteristics.

Out of the interviews, 640 initial codes were obtained that were classified in the process of analysis into two main categories: "caregiving is worthwhile" with four subcategories, and "caregiving is sensitive" with three subcategories (**Table 2**). These categories and subcategories represent strategies to combat ageism in the care settings from the perspective of nurses and physicians participating in the study.

Category 1: Caregiving is Worthwhile

Most participants' said that if the patient's family, caregiver, and caregiving system valued the health of the elderly, caregiving for the elderly and quality care would improve. In this regard, care for the elderly should neither be regarded as useless nor be considered an additional cost for the elderly; instead, people should be encouraged to promote elderly care activities.

Not Considering Caregiving a Useless Task

In the process of caring for the elderly, some cases were observed in which caring was just a pretense and finishing the job. Most participants believed that older people do not require quality care since they are aged, and no matter how good quality care was provided, the outcome would be discouraging; ultimately, this would result in disappointment in caring older people.

"You have to work hard to take good care of the elderly, and it makes you tired and finally says, OK! He's old! What can I do for him? So what? Eventually if he does not die now, he will, several days later, so why should I try in vain when there is no use. But I think I shouldn't think that way. We shouldn't allow ourselves to decide on the death or life of the patients. We must know that life is in the hands of God and we must provide our care with no judgment." (A male nurse, with 10 years of experience)

Not Considering more Valuable Dead Older People than Alive Ones

Although death and life are interrelated concepts and the sides of the same coin, many people see death as a taboo and are reluctant to talk about it. But sometimes the older people come to a phase of life where death is their last wish. This feeling also spreads to caregivers, which can lead to being reluctant to provide caregiving. For example, a participant said:

"... In cardiopulmonary resuscitation, if the patient is old, nothing or little is done. They assume that the old one did his time and let him die. We think that if an older man dies, he has relieved. Even some older say that living is no use and or death is better than this life. So we consider aging the same as death, and consequently, we do not pay sufficient attention to caregiving. Now I recall the poem of Saadi who wrote: On the ant bearing the grain brings not strife/He is alive and joyous is sweet life" (A female nurse, with 7 years of experience).

Not Considering Caregiving Costly

The increase in the elderly population is a challenge for health care providers, family members, and the community. The rising cost of the aging period is a major concern for all caregivers. The majority of participants stated that these costs affect the quality of services provided to the elderly and cause discrimination in the provision of services to the elderly relative to other age groups. To prevent such incorrect issue, they suggest that we should do something so that the older people are not only seen as a burden on the shoulder of society and the family but be considered as social capital.

"…I have to say that some people do not believe in caring for the elderly, and they are surprised and publicly opposed when you care for the elderly. Why do we impose a cost to the family and society because of

people that if they do not die now, they will in a few months or years? They ignore that older people are full of experience; if we look and pay attention well, we can be benefited from their experiences." (A head of hospital ward, man, with 20 years of experience).

Motivated for Caregiving

Occasionally, we see caregivers neglecting the demands and problems of the elderly and failing to provide services as needed so that the provided services lack the motivation to do his job correctly. Most participants considered motivation a suitable factor to improve care for the elderly.

"I have to say, if the care system does something to increase the motivation of the elderly caregivers, I think the care will improve. For example, the care system can be motivated by reducing the working hours, reducing the number of patients for caring, or presenting incentive leave; all of these may enhance the caregivers' desire for better care for the elderly."(A male nurse, with 12 years of experience).

Class 2: Caregiving is Sensitive

Being Sensitive to the Health of Older People

Being sensitive to caring for the elderly can prevent a shortage of care for the elderly. If the family, caregivers, and care system monitor the care provided to the elderly, their health would not be threatened but be taken care of. In this regard, a participant, comparing the care of a pregnant woman with an older adult, said:

"Caring a pregnant woman is harder than an old person; so, why do we care more about her? For example, yesterday, we had a pregnant woman referred to the clinic, and I put all my work aside and started to take care of her. Why? Because they care and check. Both the family and the system will punish you if you care for her less. But it is different for the elderly. Since they need much care, no one is going to check them, neither the system nor the family. Thus, caring becomes less important. If the orderly's family, managers, and the system of caregiving for the older people refuse to be sensitive about the elderly, they would never be ignored" (Male nurse, with 5 years of work experience).

Supervising and Follow Up

Supervising is an important issue in any system that improves communication and quality of service. The care provider system can influence the quality of provided care by monitoring and following up the caregiving for the older people.

"If a young patient in our ward calls us, we will respond to his request hesitantly, because we know that if we do not care, he may pursue and complain and someone is there to support him; but if the patient is an old one, no one will pay attention because there is no one to support him. Direct supervision and follow-up of elder care will prevent any shortcomings or negligence." (Female nurse, with 10 years of experience).

Education and Culture Building

Every behavior and cultural action is a communication event, and every communication action is a cultural event. The valuation of older people must be started and practiced within the family from early childhood to be accepted in the community, too. For example, a participant said:

"In my opinion, the culture of valuation forms in the family, and this has to be taught from childhood. We should watch our behavior toward our parents and elders before our children. Do not say something that our kids tell us the same when we grow old. Values move around and change from one generation to the other. The basis for valuing older people is in the family and should be institutionalized from childhood." (Male nurse, with 3 years of experience).

DISCUSSION

The purpose of this study was to elaborate on the experiences of hospital caregivers about strategies to deal with ageism in care settings. The results showed that the valuation of care by the community, family, and care provider system had a positive impact on the acceptance and provision of quality caregiving to older people.

The participants believed that quality care for older people could be achieved by one hand confronting the attitude of "considering caregiving useless and costly," and on the other hand, by motivating caregivers. In the past, aging was considered a value and the older people often provided the knowledge, experience, and independence of the family. With societies' advancement and industrialization, the older people lost their authority, and as a result, the value of the elderly in the family and community declined. Loss of power and separation from family members are the main causes of ageism (Butler 2009, Ayalon and Tesch-Römer 2018). Grefe (2011) believes that communication between different age groups, traditional family life, or having an older adult at home are some ways to confront ageism (Grefe 2011).

The participants also believed that valuation and respect for older people should begin from childhood and within the family, which is consistent with Carmen's (2018) study, which suggested an intergenerational approach to confront ageism (del Carmen Requena et al. 2018). Pettigrew (2008) believes that the gap between the generations is the cause of ageism in today's societies. He believes that the contacts and relationships between the people of different age groups enhance communication and influence the attitude towards older people (Pettigrew 2008, Maglangit et al. 2016). Both the quantity and quality of these contacts and communications help improve attitudes towards older people. Quantity and quality of communication are respectively more effective in improving implicit and

explicit attitudes toward the elderly (Grefe 2011, Sargent 2017).

Participants in the present study suggested that caregivers can become sensitive to caring for older people by supervising and building the culture folder people's care in the community and care settings. This is a step in confronting ageism. Educating people and assigning them to take care of the elderly can impact the health and care of older people. This finding is in line with Cottle's (2007) study, which believes that changing attitudes and increasing knowledge about the elderly can help combat ageism (Cottleand Glover 2007). Education corrects misconceptions and wrong attitudes toward older people (Samra et al. 2013, Sarabia-Cobo and Pfeiffer 2015). Studies have also shown that not only the health professionals should be educated about the elderly, but older people should also be educated about aging and the benefits of aging may affect attitude toward self-discrimination (Bardach et al. 2010, Wolff et al. 2014). This finding is consistent with the systematic review study done by Liu (2015), who found that the employed nurses' attitudes were more toward caregiving for older people compared with nursing students.

As we grow older, because of the internalization of society's negative attitudes and clichés toward the elderly, we experience discrimination from others, and even ourselves. This attitude explains why older people try to make themselves look younger and instead of being proud of their aging, limiting their thoughts and feeling ashamed of getting older (Officer and de la Fuente-Nunez 2018). Therefore, to confront ageism in hospital care, we need to implement strategies, predict possible paths to discrimination, and facilitate effective discrimination assessment methods in hospital care to older people (Officer and de la Fuente-Nunez 2018, Snyder 2007). Successful implementation of these endowers requires comprehensive planning with supportive monitoring and evaluation (Sao Jose et al. 2017, Akar et al. 2018, Kumar et al. 2019, Bulgakov et al. 2018, Loghmani and Monfared 2018, Kahveci et al. 2018). Long-term care programs should also be designed and supported to prevent discrimination in the care provided to older people. Valuating caregiving and making caregivers sensitive toward care for older people can be helpful in this planning. Finally, to my view, as a researcher in this field with some clinical work experience in the care of the elderly, to confront discrimination in care settings, besides research, education, and culture building, we need a fundamental change in professional behavior because ageism encompasses all people in society since aging is a stage of life.

This qualitative study presented the experiences and perspectives of a small group of health care providers in hospital settings in the Iranian context and culture. Therefore, it is notable that to strengthen the findings of the study, we should conduct studies with other caregivers in other settings too.

CONCLUSION

According to the results of the study, the participants believe that valuation (caregiving is worthwhile) and alerting (caregiving is sensitive) are the most important strategies to confront ageism in care settings. Therefore, health care decision-makers and authorities can reduce ageism in the care provided to older people by designing programs to promote the valuation status as well as alerting caregivers to care for the elderly. Health system policymakers and medical science educators can also play an important role in reducing ageism in care settings by planning and implementing measures to enhance the valuation of caregiving for the elderly and to increase the sensitivity of caregivers toward their task.

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